Creating equitable access to high-quality family planning information and services:

A Strategic Planning Guide

This Strategic Planning Guide is intended to guide program managers, planners, and decision makers through a process to identify inequities in family planning and interventions to reduce them. The guide was developed through consultation and deliberation with technical experts in family planning and health equity and builds upon the discussion paper on equity in family planning developed under the Partnership for High Impact Practices for Family Planning.[1]

> *"Equity is the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other means of stratification. 'Health equity' or 'equity in health' implies that ideally everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential."* World Health Organization[2]

Equity in family planning does not mean that all groups use contraception—or specific methods of contraception—at the same rates. Rather, equity is realized when all individuals have access to high-quality reproductive health information and contraceptive services, including choice of methods and availability of those methods, that reflect their values and preferences and the context in which they live—regardless of age, sex, disability, race, ethnicity, origin, religion, economic status, or other factors.

Figure 1. Equality, equity, and justice

Graphic adapted with permission from King County, WA.

Figure 1 depicts an example of equity. In this example, various populations are represented as figures of different sizes. This is not intended to suggest differences in value but rather to show how the assets of different groups are accommodated to a greater or lesser extent by the existing system, as shown by the fence and the boxes. Providing everyone equal support to see over the fence does not result in the same outcome for all spectators. Equity recognizes population groups may require differing resources to overcome barriers in the existing system. Justice takes an additional step to acknowledge and address the barriers directly and seeks to remove the barriers, indicated by the removal of the fence.

The following steps are intended to help program planners, managers, and development partners identify family planning inequities and develop interventions to address them.

Step 1: Determine whose needs are not being met.

To begin working toward improved equity in a family planning program, consider all defining characteristics of a population group that may play a critical role in shaping how these groups access family planning.[1] Analyses such as those included in the Demographic and Health Surveys (DHS), however, typically use wealth quintiles to assess inequities. While living in poverty is a common experience among individuals experiencing worse health outcomes, analysis based on economic status alone may conceal important social and environmental considerations for program design. For example, being an adolescent or unmarried person can limit access to contraception, regardless of wealth. Programs that focus on women, exclusively, may miss opportunities for male engagement. Geographic location may affect a person's ability to get to a facility, as well as which methods and services are available. Table 1 describes three categories of characteristics that may contribute to differential family planning outcomes. Be sure to consider how

combinations of these characteristics may affect access to information and services.[*] An adolescent from a poor household who is part of a minority population group is likely to have a very different experience in accessing care than an individual with only one of these characteristics.

Table 1. Categories of characteristics potentially related to inequitable family planning outcomes

Economic	Wealth, poverty, income stability, employment, occupation
Social	Age, race, ethnicity, caste, sex assigned at birth, gender identity, sexual orientation, religion, nationality, language, education, disability, social and gender norms
Environmental	Geographic location (urban/rural, distance from health services), humanitarian setting

Using the characteristics in Table 1, first identify the population groups whose needs may not be met by an existing family planning program and the reference groups to be used as a comparison for monitoring and evaluation. The reference groups can be national averages or a defined population that may have greater access to resources, such as the wealthy. Next, determine which measures to use to assess whether the population groups are being fully served by the family planning program. While contraceptive prevalence rate (CPR) is an important measure of family planning program implementation, it is not sufficient to fully understand inequities in family planning. Consider using a combination of the following measures to more fully understand how groups are or are not able to access family planning services, information, or methods, compared to the reference groups.

- Are those who want to delay, space, or limit their next pregnancy using contraception? Look at percentage of demand satisfied[†] and reasons for nonuse among women who do not want to become pregnant in the next two years but are not using contraception.
- Are members of this group more likely to experience an unwanted or mistimed pregnancy? Do they lack contraceptive autonomy? Consider differences in reported unwanted or mistimed pregnancies and ideal family size.
- Are members of this group at higher risk of adverse events from a pregnancy, including maternal mortality? Consider differences in adolescent pregnancy rates, short birth spacing, high parity, and risk of unsafe abortions.
- Do all members of this group have physical access to family planning, without barriers of geography, stigma, or discrimination? Consider data on locations of health facilities/pharmacies relative to where group members live, experiences of stigma and discrimination, and provider attitudes and practices. Many of the data on the indicators are available through DHS, accessible through the STATcompiler, while others may be collected by the ministry of health or at a programmatic level. The following resources may be helpful:
    - World Health Organization Equity Assessment Toolkit
    - Family Planning Equity tool, which identifies inequities for seven commonly disadvantaged groups based on DHS data
    - Reproductive Empowerment Scale and the Reproductive Autonomy Scale
    - Performance Monitoring for Action (PMA) DataLab tool and reproductive empowerment tool
    - Client poverty status measurement process
    - Service Provision Assessment client exit interviews and provider interviews

[*] Intersectionality refers to the overlap of more than one category of discrimination, such as race, class, and gender. For more information see: Crenshaw K. Demarginalizing the intersection of race and sex: a black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*. 1989(1):8. Accessed August 6, 2021. http://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8

[†] Demand satisfied is calculated as the number of all women ages 15–49 using any modern family planning method, divided by the total number of all women with unmet need plus women currently using any family planning method. See https://dhsprogram.com/data/Guide-to-DHS-Statistics/Need_and_Demand_for_Family_Planning.htm for a full definition.

Step 2: Determine what barriers individuals from this population group face in accessing high-quality family planning information and services.

After the population groups facing inequities in family planning have been identified, the next step is to define the barriers the target population faces relative to other population groups. Potential barriers leading to nonuse or unmet need are lack of access to information, services, and supplies; restrictive policies; stigma; and social, cultural, and gender norms. The social ecological model is a useful framework to consider constraints at multiple levels.[3] The process of defining barriers should be conducted in partnership with clients from the group,[4] and the following four questions about barriers should be considered:

1. Do the barriers lead to disproportionate family planning outcomes for the population group relative to the reference group?
2. Are the barriers amenable to effective interventions?
3. Are the barriers undesirable?
4. Are current interventions to relieve or reduce this condition less available to the disadvantaged population groups?

These tools may be helpful in defining barriers:

- How to Conduct a Root Cause Analysis
- A Practical Guide to Conducting a Barrier Analysis
- The Social Ecological Model
- The Social Norms Exploration Tool (SNET)

Step 3: Make the family planning program more responsive to the values and preferences of all people.

Once the barriers and root causes are identified, programs should continue working with members of the population group, the communities in which they live, and the providers that serve them to design or adapt interventions most likely to lead to sustainable change. A landscaping activity is useful to understand current efforts as well as lessons learned from previously implemented programs. In addition, an asset-based analysis should be conducted to brainstorm locally derived solutions to overcoming barriers. Nearly 60 organizations have worked to develop 20 evidence-based high-impact practices (HIPs) addressing environmental equity (expand method coverage and choice), social equity (reach underserved populations), and economic equity (reduce financial barriers), and these HIPs have been published online. The community health worker HIP emphasizes the importance of these workers reflecting the population groups that face inequities. Community health workers can address barriers to care-seeking by bringing services into clients' homes or accompanying them to health visits to bridge language and social barriers. The social marketing HIP describes how social marketing programs can reduce out-of-pocket expenses for products and services and create promotional campaigns that respond to the needs, preferences, and concerns of population groups facing inequities. Read through the HIPs to learn how to make programs more responsive to the needs of all groups. Though programs targeted to one population may be costly, these investments may produce future savings.

Once the three critical equity pieces have been determined—whose needs are unmet, the driving barriers, and potential interventions—a theory of change can be created. The theory of change will map out the program conditions that need to be in place to reach the long-term goal of reducing inequities in family planning. Developing a theory of change that is comprehensive, but not overly complicated, may be challenging. These publications provide a helpful reference:

- Using Theory of Change Frameworks to Develop Evaluation Strategies for Research Engagement: Results of a Pre-pilot Study
- Building a Theory of Change for Community Development and HIV Programming: The Impact of Social Capital, Stigma Reduction and Community-level Changes on HIV-related Health Outcomes for Orphans and Vulnerable Households in Mozambique

Examples of theories of change include:

- Transforming Social Norms for Family Planning and Reproductive Health, and at an intervention level, Transforming Masculinities
- Adolescent Girls Empowerment Program
- HIPs including family planning vouchers, community group engagement, and domestic public financing

Step 4: Monitor implementation.

The theory of change should provide ideas about how program success will be defined and measured. It should include an approach to monitoring program strategies to test assumptions and to inform adjustments in program response—with population group input. In addition, program implementers should regularly monitor outcomes. For example, programmatic results data can be compared with national data. Monitoring data should be disaggregated by age, region, and other factors to enable analysis of equity and prioritization of equity-related programmatic adjustments. Gender-based violence and other potential unintended outcomes of increased family planning information and use should also be identified and monitored. Information from clients should be collected and analyzed to determine if the care received was free from stigma, discrimination, and bias based on age, marital status, ethnicity, and other factors. Quality improvement strategies can be used to address any identified issues. Sample family planning process and outcome indicators to monitor programs are available from multiple sources including the Family Planning and Reproductive Health Indicators Database, FP2030 and PMA2020. Valuable guidance is also available from Data for Impact on using routine data in evaluation. Lastly, suggested measures of quality of care are available.

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